STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION
ASSISTED LIVING PROGRAM
408 Leon Sullivan Way
Charleston, West Virginia 25301-1713
Telephone: (304) 558-0050 Fax: (304) 558-2515

WAIVER REQUEST

Please use this waiver request for waiver of the ninety (90) day limitation for nursing/health care for this individual only. A request for each resident (as applicable) must be submitted as needed.

FACILITY NAME:	**TELEPHONE NUMBER:**	**WAIVER REQUEST DATE:**	Check if Renewal Y ____ N ____

RESIDENT NAME: _____ **RESIDENT ADMISSION DATE:** _____

PLEASE COMPLETE ALL APPLICABLE PARTS OF THIS FORM

TYPE OF WAIVER		**Check all that apply**	**Date treatment Initiated**	**Specify time-frame waiver is requested for:** Indefinite or 30/60/90 days	**FOR OHFLAC USE ONLY**	
					Approval Date/initials	**Denial** Date/initials
Catheter	Indwelling Foley					
	Straight					
	Supra Pubic					
Injection(s) *	Vitamin B12					
	Depo Provera					
	Insulin					
	Epogen					
	Other ( )					
Wound Care						
Dialysis						
IV Access						
Gastrostomy Tube						
Other (specify)						

Treatment Performed by: (If more than one, please specify who is performing the care for each specific waiver)		
	Facility RN/LPN	
	Hospice Nurse	
	Home Health Agency	
	Resident	
	Other (Pleases specify)	

Resident Diagnosis: (REGARDING NEED FOR WAIVER)

The facility administrator and/or RN certify that the following documents are in place:

- ✓ Physician orders for treatment are in the resident record
- ✓ Policies and Procedures for the specific treatment have been developed
- ✓ Training has been provided to staff with supporting documentation (for specific problem)
- ✓ RN assessment(s) and weekly nursing documentation (ALR) are in resident file
  *** Procrit and Vitamin B 12 injections do not require weekly notes from the RN**
- ✓ Resident service plan has been updated

By signing this waiver, I have concluded that there will be no adverse effect on the residents' health, safety, welfare, or rights if the waiver is granted.

_____ _____ _____
Name **Title** **Date**

Note: Verification of the information submitted on this request will be determined during survey. If deficient practices are identified which indicate the information provided by this waiver request was erroneous, the waiver may be revoked. *Revised 4/24/2015*